Strengthening the role of Primary Care Internationally: Delivering Accountable Care

Innovate stage

Monday 11th September

14:00 – 15:00

Speakers

- Louise Watson, Programme Director, New Care Models, NHS England
- Ann Greiner , President & Chief Executive Officer, Patient-Centred Primary Care Collaborative
- Dr Paul Grundy, Chief Medical Officer Global Director of Healthcare Transformation, IBM Healthcare and Life Sciences

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Louise:

When the five-year model was launched we had one of the delivery vehicles for the development of new models of care across England. We had, as a team; we had 50 sites across England who we were working with to develop models of care which were very fundamentally focused in neighbourhoods, so looking after local communities and then building up from a local community base for the provision of care across that community, across that locality. Really working to understand the most effective way of delivering care as a consequence of being community based.

The programme itself has been working for two and a half years now. What we have learned as a consequence of that is the fundamental necessity for partnership working across all specialisms across the community, be that health or care.

In addition to that, a common vision, so an understanding that community has about what they want to do, what they want to achieve for their community. Also, an understanding of what the community needs and what the community wants out of

its health and care services.

So, some of the people in this audience today I recognise as people who have been working with us along that journey and have been developing care models which are integrated in fashion around, really, the professionals working together. What we have learned from that is the need for the population health focus of care delivery within any system.

Richard:
Could you describe how the NAPC's model of care home is helping to support the new care models.

Louise:
Early on we aligned and partnered with the around their Primary Care home model. Many of you may know that the Primary Care home model is a model of integrated care, but for more than that, a population healthcare model focused on potential lip 30 to 50,000 population, but not constrained into that, that kind of population group.The reason why the new care models programme partnered with the NAPC and the Primary Care concept is because it developed Primary Care to very local community level at a level where the GP, where the clinician understood their community, knew the names of the Social Care workers they worked with appeared brought that care up from the community base.

So, for us, what we wanted was that we needed a bedrock in the community of health and care so our broader concepts of healthcare models we work at 500,000 population level they had something in their community which was a solid Primary Care base of delivery, not just Primary Care, but primary and community care. We have had fantastic stories of how patients have benefited from a primary care unit in their community.

Richard:
How is the NHS approaching this? Is it going to be something which eventually

comes to affect the entire system?

Louise:

From the start the aspiration was we would populate England, certainly, with 50% of England working on new care models by 2020. That concept, which was originally described has matured and it has matured into an aspiration around accountable care. We have now ten systems we are working with to develop accountable care systems within England. They are prototype is the wrong word, but they are first wave systems.

We are going to be working with them to develop the concepts around accountable care, both learning from international learning, such as today, but also learning from with a we learned from the last two and a half years of the new care models programme. The thing that is different with the accountable care systems from the care models that we've done is the scope is far broader.

In the new care models, we were talking about integration, we were talking about health and care working together. The accountable care systems were talking about system control total, so having one pool of funding across commissioners and providers and incentivising how that is used to support care and care delivery. We're also talking about accountability for things such as cancer, so cancer waits, improvement in Primary Care, mental health services. So discrete and targeted interventions alongside population health management.

Richard:

Thank you very much, Louise. Now the learning from the United States has been led for this session by the National Association of Primary Care. They are working to meet with a high range of leading people in the States. One thing they have been doing is providing this report, "providing accountable care" which is launched and 3 o'clock. Look out for that, there are hard copies available and there's a great deal of insight into there, into how accountable care works.

Our next four speakers are going to speak for three or four minutes. If there's time at the end I will ask a couple of questions before we adjourn to the transformation of care zone at 3 o'clock to continue the discussion. In the meantime, you'll be familiar, no doubt, by now with GLISSER. The system for hovering up the collect I didn't even knowledge in the session. So, if you could use it to give us your ideas and comments we will take those forward into the next session. Our first speaker now is from the States, Ann Greiner. Ann, you are most welcome.

Ann:

Thank you so much. Thank you for the opportunity to be here.I think Louise put the analogy that is very apt. We are on a journey. We began our journey before you all, but it is very much a journey and an evolution. It really started, I think, at the turn of this century when leaders in the US knew that they long knew we had the most expensive healthcare system in the world and we still do. Then they realised that with all that money they weren't buying quality.

Institute of Medicine reports came out and we realised that Americans were dying from medical errors each year, and no longer was that acceptable. I think policy makers understood that we were not really getting value for our healthcare spend. More costly, poorer quality. So, it really initiated a whole lot of activity about how do we reform care to enhance that value. A further spur was with the election of President Obama.

Policy makers realised not only would we have the opportunity to extend coverage to 50 million Americans who did not have coverage, but we could use the monumental legislation to put reforms in place to enhance value. So, there are many programmes that are a result of Obama Care that tie payment to enhanced quality, and also the centres for Medicare and Medicaid innovation were launched. That is well funded, $10 million over a ten-year period.

I think also we really were, we benefited from some of the research that looked across international models, the commonwealth fund, is a foundation based in New

York City and recognised that other systems because of the way they organised care and the way they pay had better outcomes. So fast forward. All the of this activity resulted in work to develop a patient-centred medical home model. Devised principles in 2007 Paul Grundy from IBM was one of the principle authors of these principles along with 4 specialty societies. This really was the model that the federal government state medicate officials' private plans used to develop this model.

We now have one in five physicians' practices in a patient centred medical home, these models are more patient centres, they integrate and coordinate care. They are supported by technology, they provide better access, many of them integrate dental health and behavioural health. Not long after that, we realised Obama was going to focus on health care, organisations leaders got together and realised we need to get beyond primary care and inclusive, but think about the medical neighbourhood. We had accountable care organisations, 900 of them in the US, 10% of the population is in accountable care organisation. They differ widely some of them are loosely connected networks of providers some of them with paid for performance kind of schemes, some of them are capitated and very integrated systems of care, so they really do vary.

Now in terms of results, where are we after our journey that began in 2007 and spurred along with the passage of the Affordable Care Act.

Patient-centred care home, low cost, better patient satisfaction, mixed results with quality, mixed results with utilisation. My organisation puts this report out; it is free on our website that each year shows you.

In terms of HCO, we see better quality not necessarily lower cost, so I think when you reflect on the conclusions from our efforts, we need to continue this journey we are making progress, we have not yet arrived at our destination. It is very important for us to continue the dialogue with people within the United States and across the pond and elsewhere. Paul will talk about that. That are creating these models and continuing to evolve them.

Another really important thing that we need, that we have discovered when we look at ACO's, which are the ones that are working the best? Are the ones built on a very strong and robust primary care chassis, if I can leave you with message, all of these forms, care delivery and payment, need to retain an important primary care foundation with a strong relationship between the patient and the clinician.

I am thrilled to be in this room and working with all of you, I hope we can continue our collaboration to achieve the aims we want to achieve for our patients thank you.

Richard:

Thank you. This is long haul, a tough programme, now looking at how it is taken from the States internationally. Pleased to welcome Paul Grundy.

Paul:

Taking it from where Ann left off as a foundation of delivery that works, about 15 years ago, my big boss at the time almost died of a drug interaction. That happens every 3 minutes in the United States, we had partiality care, my boss would have a partialist for every organ system. Without any adult supervision, right? That is a dangerous thing to have, in the US, we have a complicated system, we won't go into it but, I was asked as somebody who is buying care for their employees what are we buying? Is it of real value in?

We discovered that only 26% of our employees really had a relationship and trust with a healer in their life, in a sense you would know of that in terms of primary care in the UK. So, began looking at systems of care that worked around the world, New Zealand, Denmark, England. Interestingly enough, a lot of these early principles that came into the concept of the medical home, came from people been to America and spent time in the US.

You had a much deeper fundamental foundation of primary care than we had, we had to build it from scratch. So, interestingly enough, when I look at what I think is

probably some of the best primary care in the world that in Denmark, it really is, it really is a relationship of trust that is lifelong.

So, when you go to a Danish Medical School, the very first class that they have is how to create and maintain a relationship of trust between a healer and their patient. I took the leadership of Kaiser which by the way is considered the best accountable care organisation in the United States, to see very good primary care in Denmark and what blew them away was that we never found a Dane that didn't know the name of the primary care doctor. You wouldn't think that is special, believe me for America that is, the other thing when we discovered when we looked at the work of Barbara Sarsfield.

If somebody had a relationship of trust with a healer this their life. It cost us 31% less money. There was a 19% better 15-year survival curve on the population, there is something special we as humans need, so we began asking the question, you know, what is the basic building blocks of a delivery system that is going to work, if you don't have one at all? We didn't right.

So, it is really transforming what a primary care doctor does to come a comprehensivist, they are the system integrator, they are the team of folks that wrap around a patient on and there is accountability for managing every patient with a plan. Does that make sense to you? I mean my cat gets notified to me, my cat has a registry, my cat has a plan, when I started the journey, I took it down to the GP, how many women over 55 have never had a mammogram, I hope my door at 9, I have no idea have not had a mammogram. That process saved the life.

It is really thinking about moving towards redesigning practices, this is happening all over the world. Redesigning practices so they manage the population. If you do that, pay them to do that and stop paying them to do an episode of care. So, where this falls down quite often is when the payment is not aligned with what the expectations of this society want.

The third leg of the stool, you guys do this a lot better than we do, it is the systems design, how you integrate across the opportunity. When I visit New Zealand, Plymouth, I see how your medical homes included people involved in housing, Social Services, you know, mental health services, I mean they are all integrated into the concept of a team approach to care. We duplicated that in Vermont with your Blueprint for Health about ten years ago, again looking at different parts of the world. I was in Vermont about 2 years ago, 2 cents out of every sick care dollar, this contributes, pulls together all the not-for-profit in the community, all gather around, literally every patient has a plan.

We have seen a 60% reduction in blindness. These are the ideas that came out of southern island in New Zealand and north in Denmark. We had the opportunity and fellowship to learn from each other as we travel this journey. That's just a delight to you know, be interacting with you guys in the UK.

I think that you have a much firmer foundation of primary care than we had. But it has got to get better, I can tell you, you know, the amount of money spent in primary care has been declining and we would love to be part of your solution as well. So, thank you.

Richard:

Thank you, a powerful message about the evolving role of the GP and the care plan and with the team absolutely.So, to translate this into what it might mean for the NHS, firstly welcome, Dr James Kingsland, the President.

James:

Thank you, on the transatlantic journey, from hearing where the accountable care systems from inception and the organisations, having been part of the creation of the primary care home designed by the NAPC we wanted to look at how it would fit into the developing accountable care system debate within the NHS.

We have seen the rapid development of STP's, which weren't necessarily part of the

health and social Care Act and they have gone quickly from plans to programmes, to organisations, to accountable care systems and now talking about the delivery model. So, we were keen to explore what we had created in terms of the primary care home and its implementation to date and interestingly, and we heard about 10% of the coverage, we have 14% already with the primary care homes in the UK model. We want to make sure it aligned with the accountable care systems within the UK but learn from where it was designed.

So, make sure we had a strong evidence base put the experiential learning in place, which was the, where we came from, for the creation of the primary care home. Designed over a 25-year process. So, we have tried to learn from reforms to date, what has been successful; what has failed. So, we have got a care model that Nav is going talk about in detail.

Going back to the US for a moment. I just wanted to reflect on a, a quote which I think has come from the institute for health care, improving the IHI, Don Berwick, every system is perfectly designed to get the results it gets, for the last 18 years, the NHS reducing waiting times from 18 months to 18 weeks but perfectly designed to increase admissions, not facilitate early discharge. Have extended stays in hospital. Therefore, we need something to design as well as the access issues, the awaiting and the access, which is often the public's main concern, a design that facilitates the aspirations of the 5-year view, then reflecting the commonwealth fund report of this year, mirror, mirror, which has the international comparison of 11 OEDC countries, looking at where the US and UK are compared.

The UK overall comes out number one in national health care systems but in care process, in access, in administrative efficiency and in equity. But sadly, number ten in health care outcomes. The US is number 11. So, there is something about accountable care systems that are designed to improve the quality of care, whilst curtailing costs, so we need to describe something where we may have good equity and good admin control, good regulation and access, but haven't got the outcomes we desire or patients deserve.

So, the primary care home needs to be part of the solution, learning from the accountable care systems we will be incorporating.

And the final reflection is on what the Health and Social Care Act much vilified of 2012 was trying to design. Despite a huge piece of primary legislation, if you boiled it down to what it was trying to deliver was accountable. Accountability for outcomes, hence the outcomes framework and the 5 domains and accountability for resource deployment.

So, we were saying can we align clinical decision making with the costs of the resources that were used as a result. So inherent within the Health and Social Care Act, was something about accountability and accountable care.

The best of the accountable care organisations, what I have seen and hopefully colleagues in the US don't push against, when you have seen one organisation, you have seen one organisation. There are different models we are not saying that the primary care home is the panacea, but incorporates the principles of accountable care. Having a well-defined population, driving up quality within fixed resources and driving down cost and improving efficiency and a provider organisation based in a community setting, now there is different ways of delivering that, but the primary home care model is based on the foundations, fits in well with what Ann was describing, the reason for systems developed in the US and having been exported internationally already, we need to now import the best of that learning and make sure we have got a strong evidence base and fits the delivery system within the NHS.

When I first met Ann, we were in Washington recently, she said, interesting, you want to have an accountable care system in the UK. You've got one, it's called the NHS. We just need to improve efficiency, particularly in outcomes with, as we know, the limited resources. So the Primary Care home is a model we are testing general practices the models in America and internationally to give some sense of a provider

model and the provider model has core principles, not a blue print of how you deliver the care, but an evident based with a size that serves, so we don't lose the localised care that patients want, but have a size that improves population health management which will lead to the prevention agenda, which we've strived for within the NHS for a long time.

So, we have a model that has principles that also look at how we are accountable for budgets, how we drive up better outcomes, how we deliver the aspirations of the Five Year Forward View and have a health service that is designed to facilitate early discharge, self-care, managed in their environment, extended care in their communities with a model that seems to be capturing the imagination of our colleagues both in health and social care.

Richard:
Thank you, James. Our final contributor who is going to flesh out how the model might work in the UK is Dr Nav Chana. Nav.

Nav:

Just as I come off the subs substitute's beverage, to complete the session, I want to repeat what has been said. The Primary Care home is built around principles. I would like to articulate what those are, but in many ways link back to the learning that we picked up from our colleagues in the United States, particularly around the Primary Care home collaborative. In particular some work done by, Thomas Bodenheimer. Those of you interested, I would say to read his article for ten building blocks for high performance accountable care, which I think describes some of the things we need to put in place as we go on our journey to developing account care systems. As I looked at that system, and I'm not going to iterate all of those, as we conceptualise it, we have incorporated many of those building blocks in our design, and that is very reassuring.

I would like to start off by describing Primary Care and why it is so valuable. It is, as

colleagues have said, that part of the system that connects an individual within the context of a population health responsibility. Sadly, I think, in this country, although, obviously, we are renown to be the primary origin of Primary Care as we would wish to describe t we lost our way as we have fallen into a reactive illness as opposed to a whole person, whole community model of care. So, the Primary Care home tries to rebuild based on the strengths of Primary Care.

Those are a commitment to high quality first point contact care. I know that's the not just that care delivered within primary practice. A lot of Primary Care happens outside primary practice. We have to ensure we have a system that incorporates that as much as within genre practice. The second bit is the whole person orientation. A person is built up of more than one organ who sits in a family or community and who is responsive to the broader health.

So, we really have to think about how we bring together a multi-agency response to drive up that. The third thing is that extensiveness of care we all espouse from prevention to great quality end of life care when people need that and not just pick out bits because it is easy to do those and easy to measure those. The fourth bit is coordinating care when it is needed from other parts of system. That coordination of care can be through other parts of the healthcare sector, but it may require coordination within our communities or within our Social Care provider agencies. So, it is really important to think about those four functions of practitioner as we think about the Primary Care home care model. So, what has been articulated is for any of this to work it has to have commitment to population health management. That is one of the founding principles of the Primary Care home. It is a commitment to whole population health management which requires data driven evidence to how you target interventions appropriately to those segmented interventions. It is about a multi-agency response to driving that model of care. I think we alluded to that already.

It is important to focus on the tact that a large proportion of the population at any one time are healthy. So, we need to keep the focus on health and wellbeing and not

obsess about those who have illness. Otherwise we create the health inequalities we are seeing in this country. So, it requires focus on those who have health and care needs designing a response around that. Through data driven population driven management approach. The third thing I feel passionately about is team based care. I want to reframe that as quad based care. Because a squad incorporates teams of teams.

It is not just one team, a squad of people coming together with specific skills and competencies designed around the segmented needs of particular part of our population. So, there are teams within teams and overall, we're creating a squad.

One of the things I was impressed with in Bodenheimer's work is how you drive that team based model of care. So, it is not just about numbers. Clearly, we need numbers, but it is not just about numbers, it is about ensuring that you're liberating people with specific skills to do the things they have been trained to do as Paul was alluding. So, the general medical Primary Care is an extensive care, not someone who is responding to illness. Someone who can espouse and deliver against what they were trained to do. To use a sporting metaphor, you wouldn't have your striker playing left back, would you?

So why would you have your highly trained medical practitioners practising in a particular way but not using their skills supported in a team to enable them to do that. The fourth principle, I think alluded to by Louise is what should the size of the population be? As you know, and our learning from the States, the smaller the population, the better, but there has to be a point at which you aggregate upwards to get the benefits of scale. So, we have been working around that 30 to 50,000 population, registered population as the key component of care. I think if I may steal one of Paul's affair I seem, we all obsess about size and governance, but it is about operating small from the base of big. Who people want is highly personalised care which is small, pertinent, relevant to them.

Whether that is driven through an organisation this big or that big, I don't think people

care about that. That is an important lesson. It has been a privilege for me to work with our colleagues from the States. NACP would like to announce a formal affiliation with the PCPCC so we can continue to drive our ongoing learning around these important areas. As has already been mentioned, we will be publishing this report which picks up many of the things our colleagues have been talking about.

Richard:

I think it would be good if you Tweeted the link to the book. I think many would like to see that. Put it on the expo hash tag. Ann, you said in your early assessment of where it had reached in the States you were getting control of that horrible cost conservative in America, but there was a mixed picket or quality. Is that early teething problems or more complicated than that? Will you get there with quality, I guess, is the question.

Ann:

We think that we will. We have evidence of health plans that have been consistently focused on patient centred medical homes over eight years, for example. Like the Blue Cross Blue Shield plan in Michigan, which are written up in the report, show fabulous outcomes, cost, quality, patient satisfaction and utilisation. So, the result of this review and in an as I say demonstrates it takes four or five years to see consistent results. So, a lot of what we see as mixed is some of the early adopters, you know, two or three years in, where you don't yet see those results. What also is true in terms of research design is that the model continues to evolve, so it makes it very challenging for the researchers to see the results over time. You don't want to stop that evolution, you want to continue to innovate, that is one of the challenges. Back to the ten points, and I'm going to borrow another phrase from Paul, this is not a silver bullet.

This is a multi-faceted reform. It takes time over the time period. We need persistence. A lot of it. Policy makers like the silver bullet, they like it done fast. This will take time, persistence, resources and leadership.

Richard: Paul, please come in.

Paul:

To rephrase that in a simply term. Those practices that followed the ten building blocks carefully and actually delivered that, none of them were not successful. When elements of that weren't there, so if you didn't have leadership, if you didn't have followership, those elements that are part of the building blocks, yeah, you're less likely to succeed. But it isn't complicated. Honestly, those ten building blocks are very fundamental and foundational, leadership, followership, time.

Richard:

Do indicate if you would like to we have roving microphones. We find it difficult moving from organisation focused to system focused. We know that's what we want to do, but it is tough. Do you have any advice for how you make that work?

Paul:

I think the Romans did it. If you have 100 or less in a squad, they'll die for each other, if you have 100 or more they'll kill each other. The Danes have done this well. You want the delivery to be small enough it is intimate and personal. But the structure around it, the information technology, the payment system, to be large enough so there's scale. It is matching those two things together. Again, that's not rocket science, it is just simply thinking about it in those terms. So, the Danish system is a great example to look at. You know, any Danish doctor can cover for any other Danish doctor. The system is designed to do an incredible job of that. But I can tell you that at the practice level, you know, there are four or five docks in a group that is never larger than 4 or 500 on a team. I think you guys are getting that concept as well.

Richard:

You think 30 to 50 is the ideal spot in terms of good care but also managing to reform the system. That Paul has mentioned the size of the work force squad, relating through the set of relationships, through a narrative based style of care,

education, training, supervision, focusing on the roles, the squad is constructed around the needs of the. We have made many mistakes in thinking work force planning happens at a national level, where what really matters is how you design the work force units around the defined populations.

The questions on the screen there.

James:

We are not saying the -- if you balance the population health analysis and need but not lose personalised care, if you risk manage a dedicated budget, if you have only got a work force that runs as a team, it is the right place to start. My words in the past, where magical thinking has changed an organisation or size of services, this has as strong evidence base as it is, we are saying that is the right place to start.

Richard:

Ann and Paul, questions from our audience, focused on the US model. A good question voted on heavily there. What is driving the cost versus quality issue, Ann?

Ann:

Well I think we have, we do not have standardised metrics and so that is part of, the challenge in terms of the quality piece. We do see in terms of, cost reduction in the patient set of medical home model that we are able to reduce emergency and readmissions, the patients in the medical care home model.

That is on the positive side. Patients really enjoy practising in, enjoy getting care in these models as do physicians and other clinicians like practising in these models. That is very, very important in terms of really not only the, the clinician satisfaction but we know it has effects on patient outcomes. Paul may want to add to those remarks.

Paul:

Frankly speaking, we are coming out of World War II we evolved the health care

system that is a milking machine, seriously, to every system designs thinking. I mean, it is, it is, it is, when you pay for episodes of care, you are going to get for too many, we have been paying for only episodes of care, at the hospital, "we do the best heart surgery," that is not the sign I want to see, we do a good job managing our patients, there is one third surgery needed.
But we have evolved a milking machine in the U.S.

Richard:
The issue of joining the work place, something discussed in the UK and something which is the primary care home evangelists say that it does bring to the work place, clinicians motivated is the heart of it.

Before moving to the transformation of care zone, James, another question from the audience, what are the two or maybe three things that the UK can learn from the US accountable care systems?

James:
To be clear about the definition about what we mean, clarification of the language, we were talking in the production of this, when first meeting with our US colleagues, Nav's was the word soup, or the acronym we have, clear in language and consistent sign language in delivery, what we mean in in the UK by accountable care principles.

Secondly, we picked up the joy within the work force and there is good evidence from the US about how important it is and I think we are starting to recognise the biggest financial risk to our NHS is the moral of the work force. If we don't get that right, if we don't get the environmental factors right, we may still have people who are, have their vocation, and a professional outlook but are fatigued, low morale and can't deliver the change, that is what we are finding with the primary care home, access and patient waiting is the top concern. The staff, to have better work life balance purpose. We have to be clear about that.

Thirdly clear about what we mean on the alignment of financial and clinical

responsibility or accountability. We can't formally change accountability without legislation, but the responsibility of the people who are delivering the care are responsible for the resources therefore with any reform, often we try and enact care reform without financial flows or reform.

Richard:

Can I thank Louise, James, Paul, Nav for their contributions today. Can I thank MSD for their support for the work and the entire Expo event? 3:00 o'clock in the transformation of care zone, questions will continue for our Panel, look forward to seeing you there, thank you.